Consultant Travel Claim Procedures:

- Airfare, car rental and taxi fare charges will be reimbursed by CSD (tips not included).
  Private vehicle use (not company vehicle) will be reimbursed at .34 per mile.

- Hotel lodging will be reimbursed up to $84.00 + tax.

- Traveling Expenses for allowable per diem reimbursement rates for trips **less** than 24 hours:

  $6.00 – breakfast (if travel begins at or before 6:00 a.m.)
  $18.00 – dinner (if travel begins at or before 4:00 p.m. and ends at or after 7:00 p.m.)

- Traveling Expenses for allowable per diem reimbursement rates for trips **more** than 24 hours:

  $6.00 - breakfast (if travel begins at or before 6:00 a.m.)
  $10.00 – lunch (if travel begins at or before 11:00 a.m. and ends at or after 2:00 p.m.)
  $18.00 – dinner (if travel begins at or before 4:00 p.m. and ends at or after 7:00 p.m.)

  A **$6.00** incidental may be claimed for each full 24 hours of Travel.

- STD 262 Travel Expense Claim form.

- STD 204 Vendor Data Record

- CSD 491 Consultant Travel Expense Claim

- Complete STD 262 Travel Expense Claim form, CSD 491 Consultant Travel Expense Claim form and STD 204 Vendor Data Record and submit all documents **plus original receipts** to CSD for reimbursement.

State of California
Department of Community Services and Development

CONSULTANT TRAVEL EXPENSE CLAIM

CSD 491 (Revised 2/03)

Consultant's Name:_____

Agency/Company:_____

Address:_____

Date of Travel From:_____ To:_____

Departure Time:_____ Return Time:_____

SUBSISTENCE ALLOWANCE (MEALS/LODGING):

Number of Nights Lodging_____
(Original receipt required)

Subsistence Allowance_____ **(Based on current state rates)**

TRANSPORTATION:

Air Fare $ _____ **(Original receipts are required for all air travel)**

Car Mileage @ 34¢ per mile _____ (miles) = $ _____

Taxi/Airport Shuttle $ _____ **(Original receipt required)**

Rental Car $ _____ **(Original receipt required)**

Toll Fees $ _____ **(Original receipt required)**

Parking $ _____ **(Original receipt required)**

BUSINESS EXPENSE: $ _____ **(Original receipt required,** claims for telephone calls must include the place and party called. All other expenses require an explanation.)

Total: $_____

Signature of Person traveling: _____

Original receipts are required for items of expense claimed as indicated above. Affix small receipts to 8 ½ x 11 paper. **Submit original.** Travel expense claims must adhere to California State guidelines and regulations.

For CSD Use Only:

Amount to be paid $_____ Index Code_____ PCA Code_____

Approved by: _____ Date: _____

STATE OF CALIFORNIA

TRAVEL EXPENSE CLAIM

STD. 252 (REV. 6/93)

*See Instructions and *Privacy Statement on Reverse Side*

Page 1 of Pages

CLAIMANT'S NAME	SSAN OR EMPLOYEE NUMBER*	DEPARTMENT

POSITION	CB/ID NO.	DIVISION OR BUREAU	INDEX NUMBER / PCA

RESIDENCE ADDRESS*	HEADQUARTERS ADDRESS	TELEPHONE NUMBER

CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
	CA		[illegible]	CA	

(1) MONTH / YEAR (2) DATE	TIME	(3) LOCATION Where Expenses Were Incurred	(4) LODGING	(5) MEALS Break-fast	Lunch	O.T., LT, N/C, Relo. or Dinner	(6) INCIDEN-TALS	(7) TRANSPORTATION (A) Cost of Trans.	(B) Type Used	(C) Carfare, Tolls, Parking	(D) Private Car Use Miles	Amount	(8) BUSINESS EXPENSE	(9) TOTAL EXPENSES FOR DAY
(10) SUBTOTALS														
COLUMN CODE (ACCTG. USE ONLY)														
CLAIM TOTAL													$	

(11) PURPOSE OF TRIP, REMARKS AND DETAILS (Attach receipts/vouchers when required)

(12) NORMAL WORK HOURS

(13) PRIVATE VEHICLE LICENSE #

(14) MILEAGE RATE CLAIMED

0.34

AGENCY ACCOUNTING OFFICE USE ONLY

PAID BY REVOLVING FUND CHECK NUMBER

(15) I HEREBY CERTIFY that the above is a true statement of the travel expenses incurred by me in accordance with DPA rules in the service of the State of California. If a privately owned vehicle was used, and if mileage rates exceed the minimum rate, I certify that the cost of operating the vehicle was equal to or greater than the rate claimed, and that I have met the requirements as prescribed by SAM Sections 0750, 0751, 0752, 0753 and 0754 pertaining to vehicle safety and seat belt usage.

CLAIMANT'S SIGNATURE	DATE	(16) SIGNATURE OF OFFICER APPROVING TRAVEL AND PAYMENT	DATE
>>		>>	

(17) SPECIAL EXPENSE AUTHORIZATION - SIGNATURE AND TITLE 9 *(See Item 17 on reverse)* — DATE

>>

STATE OF CALIFORNIA

VENDOR DATA RECORD

(Required in lieu of IRS W-9 when doing business with the State of California)

STD. 204 (REV. 2-97)

NOTE: Governmental entities, federal, state, and local (including public school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the vendor

1 **PLEASE RETURN TO:**

DEPARTMENT/OFFICE

STREET ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE NUMBER

PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments.

(See Privacy Statement on reverse)

2 VENDOR'S BUSINESS NAME

SOLE PROPRIETOR--ENTER OWNER'S FULL NAME HERE *(Last, First, M.I.)*

MAILING ADDRESS *(Number and Street or P. O. Box Number)*

City, State and Zip Code)

3 **VENDOR ENTITY TYPE**

CHECK ONE BOX ONLY

- ☐ **MEDICAL CORPORATION** *(Including dentistry, podiatry, psychotherapy, optometry, chiropractic, etc.)*
- ☐ **EXEMPT CORPORATION** *(Nonprofit)*
- ☐ **ALL OTHER CORPORATIONS**
- ☐ **PARTNERSHIP**
- ☐ **ESTATE OR TRUST**
- ☐ **INDIVIDUAL/SOLE PROPRIETOR**

NOTE: State and local governmental entities, including school districts are not required to submit this form.

4 **VENDOR'S TAXPAYER I.D. NUMBER**

SOCIAL SECURITY NUMBER REQUIRED FOR INDIVIDUAL/SOLE PROPRIETOR BY AUTHORITY OF REVENUE AND TAXATION CODE SECTION 18646 *(See reverse)*

FEDERAL EMPLOYERS IDENTIFICATIONNUMBER (FEIN)

IF VENDOR ENTITY TYPE IS A CORPORATION, PARTNERSHIP, ESTATE OR TRUST, ENTER FEIN.

SOCIAL SECURITY NUMBER

IF VENDOR ENTITY TYPE IS INDIVIDUAL/SOLE PROPRIETOR, ENTER SSN.

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

5 **VENDOR RESIDENCY STATUS**

CHECK APPROPRIATE BOX(ES)

- ☐ California Resident - Qualified to do business in CA or a permanent place of business in CA
- ☐ Nonresident *(See Reverse)* Payments for services by nonresidents may be subject to state withholding
  - ☐ WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED
  - ☐ SERVICES PERFORMED OUTSIDE OF CALIFORNIA

NOTE:
a. An estate is a resident if decedent was a California resident at time of death.
b. A trust is a resident if at least one trustee is a California resident.
(See reverse)

6 **CERTIFYING SIGNATURE**

I hereby certify under penalty of perjury under the laws of the State of California that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.

AUTHORIZED VENDOR REPRESENTATIVE'S NAME *(Type or Print)*	TITLE	
SIGNATURE	DATE	TELEPHONE NUMBER